OMA accepts major Pickering recommendation

By Milan Korcok

Stepping before OMA's annual general council meeting to castigate the medical profession for its failure to maintain good human relations with patients demands more than a pocketful of courage.

And further suggesting that if some service-oriented competitive company was as neglectful of the feelings of its clients as physicians were of theirs it would go out of business, might be considered adding insult to injury.

But Edward A. Pickering, retired business executive, of the Special Study Regarding the Medical Profession in Ontario, did precisely that last month. And he not only walked out of the bulging meeting hall unscathed, he did so with the sound of a standing ovation ringing in his ears.

It was an unexpected end to a 2½-hour confrontation which many expected to be marked by animosity but which actually was a low-key, unemotional give-and-take on the carefully spelled out 125-page Pickering report.

(The report was supported by two appendices: the Economic Position of Ontario Physicians and the Relation between the Schedule of Fees and Actual Income from Fee Practice, by Dr. A. Peter Ruderman, professor of health administration at University of Toronto; and a background paper on Citizen Participation in health service, prepared by Thelma McCormack of the York University department of sociology.)

As Mr. Pickering at one point urged: "Speak up and let your good works be known." In effect it was an appeal to get off the defensive, to take a firmer grip on the future course of health service changes, to become more deeply involved with government and the community in fashioning this change, and to accept the inevitability that the profession work toward changing its own character before "a growing body of public discontent forces it."

To effect this change the Pickering report emphasized 14 specific recommendations — two of which were immediately adopted by the membership at the urging of the Board of Directors.

Joint committee on pay

The first was that *the OMA explore, with the government of Ontario, the establishment of a Joint Committee on Doctors' Compensation for professional services.*

(By way of implementation, OMA president Dr. Louis Harnick explained that the board would first look at the kind of consultation and expertise needed for such a group; it would decide on its responsibilities and terms of reference, as well as its composition and what role laymen would play. Then the board would bring forth "a complete and acceptable package" for the ratification of council, as soon as possible, very likely at a special meeting of council.)

Underlying this action was a very basic philosophic commitment for OMA members — that remuneration for services was no longer the exclusive province of the profession itself, that some element of negotiation with government was inevitable, and that some written agreement with government simply could not be avoided.

The dilemma faced by several discussants from the floor was government's predisposition to move unilaterally in setting of a schedule of benefits, regardless of what the profession decided about its own fees. But as Mr. Pickering saw it, the chances of this kind of unilateral action by government would be greatly lessened if an effective joint committee of the kind envisioned would be able to swing into action.

It was this recommendation, Number 14, dealing with the committee on doctors' compensation that yielded most of the floor debate. But there was surprisingly little opposition to the underlying Pickering opinion that the association could no longer exclusively control its own fee structure.

As he sees it, the committee responsible for reviewing and revising the schedule continuously would comprise three representatives each of the association and government.

The fee schedule itself would be under continuous study of a small secretariat under the direction of the joint committee and it would be made up of a medical economist and research statisticians.

Though the joint committee would initially concern itself with the amount of fee payments for specific procedures and other short-term matters it would ultimately go on to broader considerations of the quality of medical care, development of new methods of compensation, and seek some coordination between the OHIP schedule of benefits and the fees paid to participating physicians under the OMA schedule.

Within this context, Mr. Pickering emphasized the need to work out some arrangement by which the non-participating physicians would legally and ethically bill their patients directly for a larger amount so long as they met the conditions of ensuring that the patients had an effective option of a participating physician, and so long as the patient was informed in advance of any additional charges.

He also stipulated that the existing OMA tariff committee continue to work on amendments to the schedule and even intensify their work so as to give the association's representatives on the joint committee better support data.

"Some members of the profession will unquestionably view the recommendation of a joint committee as a radical change. There is no denying it. However, any unilateral system of fee setting under present conditions is anachronistic and is no longer socially or politically defensible."

Physicians' earnings shown comparable to others'

As could be expected, the economic status of the physician came in for a good deal of scrutiny in the Special Study Regarding the Medical Profession headed by Edward Pickering.

To guide the commissioners toward their recommendations, medical economist Dr. A. Peter Ruderman, professor of health administration at the University of Toronto, provided an appendix to the report, one that came in for a good deal of comment when the report was brought to the floor of council.

What Professor Ruderman had to show was that average earnings of physicians may not in fact be exorbitant — as some legislators and newspapers have been suggesting.

"When the lifetime estimated earnings of a plumber are in the order of $1 million, then $1.5 million for a general practitioner may not be too much out of line", says the section dealing with earnings.

"Airline pilots work under conditions of stress but work much shorter hours than physicians. The table shows them at an hourly rate of $26.10 compared with doctors at $17.40. Based on a 50-hour week, the table shows electricians in the Toronto area at $13.35 and plumbers at $12.75."

Despite this however, the report recognizes that with the total payout to physicians going up, and with the cost of physician care in the province exceeding $500 million a year, there is need to carefully scrutinize the existing methods of payment and to avoid "a collision between the profession and government."

Whether or not this recommendation was the motivating factor, the council itself voted to continue its moratorium on fee increases until more definitive data could be obtained about how physicians actually did fare on the basis of a full year of the OHIP experience.

This kind of information won't be available until the fall of this year and if they choose, council could recommend tariff adjustments at the midwinter meeting.

In the meantime however, there will be no fee increases except for new items.

The practice has been for the OMA to revise the schedule every two years. The last revision took place on May 1, 1971. The next would have normally occurred on May 1, 1973, but this was voluntarily deferred at last year's meeting, partly to enable the Pickering study to be completed and for the gathering of economic data on OHIP experience.

In re-examining the fee schedule mechanism Professor Ruderman makes these recommendations: first, identify the levelling out of income on the basis of 1971 and possibly 1972 tax data. Evidence of this kind of stabilization would provide a base line for fee negotiations.

Professor Ruderman's next step would be to determine the increase in consumer prices for the years prior to the proposed new fee schedule, the objective being to stabilize the purchasing power of physicians' earnings for the 1974-75 years at the '72-73 level.

He then suggests that at a later date the fee schedule either could be linked to an index of average wages and salaries or earnings of other professions, or as an alternative, it could be based on some criteria of physician productivity rather than being tied to the earnings of any other group in society.

Though the fee-for-service system has itself come under increasing fire from politicians and the media in recent months, the Pickering commission proposed little in way of an alternative concluding that with all its faults "we would be further ahead to concern ourselves with deficiencies in the fee system which can be studied and corrected in an orderly way."

The study group roundly rejected any "universal salary system."

"It is unlikely that such a system . . . with government providing facilities, equipment and traditional benefits for growing numbers of professionals, would be less costly than the existing method of delivering medical services," says the report.

"There would probably be poorer service as well," it adds.

Advisory committee

The second of the two Pickering recommendations upon which the OMA council felt compelled to move was *the establishment of a permanent advisory committee to counsel it on its relationships with the public.*

This committee would help guide implementation of the Pickering report recommendations, would give the OMA some input to "balance the purely medical and professional orientation of the association" and would provide a "sounding board" for the executive committee and directors on matters related to the public.

As Mr. Pickering sees it: "It may be argued that such a move will be an opening of the door to halls where the layman has no business... In any case, if an advisory committee represents an opening of doors, we see the door swinging the other way, allowing the profession better understanding, to better respect and respond to the social environment in which it functions."

Though no specific decision on the actual makeup of this committee was made, Mr. Pickering strongly suggested that its members might be drawn from the advisory council which he used in preparation of his report.

This included a broad range of consumer groups, labour and farm organizations, news media, academic, business and professional groups, hospital administration, nursing, municipal government.

Following is a list of the 12 other specific recommendations made in the Pickering report. These recommendations were all referred back for further study by the membership pending further action.

Establishment of a policy that members of the OMA periodically engage in open forum meetings at the community level; and further, that the OMA provide expert advice and assistance to local medical societies and academies in organizing and carrying out this program.

Throughout the questionnaires, the written submissions and the public hearings, the physician was often characterized as overbearing, having an arrogant manner, and using technical language beyond the patient's comprehension — as one woman termed it, an "I God, you moron" attitude.

Consequently, the Pickering commission recommended that the OMA through its local medical societies and headquarters secretariat help facilitate communication between local physicians and their communities.

The OMA inaugurate a management service as a separate branch of its secretariat.

This would be an attempt to help physicians overcome the deficiencies in their own training which ill-prepared them for running a practice, for the intricacies of managing an office, or for facilitating a smoothly run appointment system.

The management service could do research into such areas, it could train medical business managers who in turn could counsel doctors on office management, help them establish liaison with health-oriented organizations in their community, cooperate with news media, and act as a catalyst between the profession and the community.

The Pickering commission also recommended that the OMA obtain expert help in organizing a telephone answering system for the profession, first in some metropolitan area and then, once it is operating effectively, spreading it throughout the province.

That the OMA take the initiative with other interested bodies in establishing a permanent medical manpower data unit.

This recommendation was made in response to a pervasive feeling that in contrast to pre-medicare days, doctors were treating patients impersonally, using assembly-line production methods.

The public complained about the physician's reluctance to make house calls, needless specialist referrals, difficulty in making appointments, and delays in waiting rooms.

Though few had any real complaints about their physician's competence (89% of respondents were satisfied with their physician's skills), they were disturbed about hurried examinations and overprescribing of drugs.

More than half the people surveyed felt there weren't enough doctors in their community, only half were confident of getting a doctor in case of emergency, almost a third felt their doctors' offices were inconveniently located, one fifth felt that if they phoned their doctor with a problem they would not likely be able to make contact that same day, almost one third felt that appointments had to be made too far in advance.

The Pickering commission recommended that the physician himself was likely in the best position to know the manpower deficiencies in his community and that this knowledge should be used to direct better medical manpower distribution.

The report stressed that OMA should have the "statutory responsibility for determining the number of bodies needed in the Province."

That the OMA extend its joint procedures for regular consultation with the Ontario Hospital Association.

With more and more of the practice of medicine taking place within the hospital setting, the Pickering commissioners felt that the OMA and OHA should get together more often to "avoid conditions which might create serious discord to their relationship."

As the report noted, the self government of the physicians within the hospital setting plus the fee-for-service payment system presented a most delicate problem. As a recent brief by the OHA pointed out: "The most capable and responsible persons must be chiefs of staff and heads of departments. It is not unknown for these positions to be filled by doctors who depend on referrals from their colleagues... and are therefore susceptible to pressures if they attempt disciplinary measures."

Consequently, the growing complaint from hospital administrators is that peers are not prone to exercise control over their colleagues, and doctors are seldom called to account by their peers.

As the OHA sees it, this casts serious doubt over the effectiveness of the fee-for-service system in the hospital setting and it recommends that contracted

salary is desirable for medical specialists such as pathologists, radiologists, some surgeons, emergency care specialists and staff psychiatrists who practice almost exclusively in the hospital.

That OMA intensify its efforts to enlarge the role of paramedical services.

In this respect, the public opinion survey of the Pickering study showed that 82% of patients would welcome greater use of paramedical services. As the report states: ". . . changes are not only inevitable but are much more urgently required today than when discussions (about the use of such personnel) commenced several years ago."

Drop authoritarian role

One of the clear implications of the recommendation was that physicians would have to drop what the report termed their "absolute, authoritarian role" in the health services. Such a thrust would involve the profession in a definition of the assignments which can properly be entrusted to allied personnel, statutory definitions of legal liability in certain cases and revision of the bases of compensation for such personnel.

That OMA discuss with the College of Physicians and Surgeons and the Council of the Faculties of Medicine the degree of progress being made regarding both selection criteria and curriculum content in medical schools.

The rationale for this recommendation was that medical schools (for the most part) still seemed to be guided by academic standing exclusively in their selection of students, omitting such factors as the personal, human qualities necessary in the social and community context of contemporary health services.

Another area of concern was the neglect in most medical schools of the psychosocial aspects of medicine. Only the McMaster program was cited as an example of a reasonable balance between clinical and pathological aspects of medical training and the psychosocial side.

That OMA re-assess the profession's responsibilities and relations to the total health care delivery system.

Within this broad umbrella recommendation the Pickering commission directed the medical profession to re-examine the possibility of going back to the house call, to assess its viability, and to determine its cost. The report noted that this part of health services could be very essential for the aged, the incapacitated and mothers with young families.

The study group also commented on the advisability of grouping more services in convenient locations, citing public support of a multidisciplinary one-stop service. But it approached total acceptance of the much-touted community health centre as "a panacea type" of solution.

"We would be naive indeed to look for a total solution through another simplistic approach."

The Pickering report also urged more development of group practice, more home rehabilitation programs using doctors, nurses, physiotherapists and social workers, greater support of rehabilitation medicine specialists particularly via fee schedule stimulus, and it sought an end to the great fragmentation of services which forced patients to be shuffled off to several different places for a great variety of procedures — x-rays, lab tests and probably "a specialist or two."

The OMA sponsor major research projects.

This recommendation seeks research, primarily through the Ontario Medical Foundation, to be directed to more pragmatic needs such as assessing the types of care now being provided for low income groups and older persons. It also emphasizes the potential role physicians would have in detection of certain symptoms in young children — mental retardation, hearing handicaps, perceptual handicaps.

"This kind of pragmatic research is not only socially desirable, but will provide new vitality to the OMA as an association and to its public image."

That OMA develop, publicize, and give wide distribution to a patients' bill of rights for medical care and services.

As the Pickering report suggests: "It may clear the air to define what the public is realistically entitled to expect in service from the medical profession and what in turn the profession recognizes the public is entitled to expect."

Such a bill would also provide a standard against which doctors themselves as well as their patients could measure performance.

The OMA conduct a continuing programme of public education with respect to its role and activities.

As the Pickering commission sees it, the OMA has buried its light under a bushel. Its contributions to health care in Ontario have been substantial and deserve to be made better known to the public.

Obviously a project of this kind could not be undertaken by one man. A tremendous amount of research was necessary in addition to the public hearings. Those who made vital contributions to the design, planning and conduct of this research were:

Michael Hicks	director, client services marketing and communications, Price Waterhouse Associates;
Thelma McCormack	director, graduate program in sociology, York University
A. Peter Ruderman, Ph.D.	professor of health administration, school of hygiene, University of Toronto;
Oswald Hall, Ph.D.	professor of sociology, University of Toronto;
Terry Bird	director of research, Infocor Ltd., Montreal;
Thomas A. Foulkes	senior consultant, Price Waterhouse Associates.

Michael Hicks was senior consultant for the study.

Consequently, the Pickering report recommends that the OMA more aggressively publicize the work of some of its committees — child welfare, computers in medicine, health education, maternal welfare, misuse of drugs, paramedical personnel, public health and rehabilitation.

The OMA revise the code of billing ethics.

With medicare interposing itself between patient and physician, the fee schedule underwent irrevocable change. As the Pickering commission notes "The doctor's personal knowledge of his patient's ability to pay was no longer a factor." The schedule and the computer converted what had been a highly personalized billing system into a mechanical one, and consequently much of the professional vigilance that had controlled abuses (by patient or physician) went out the window.

Add to this the charges of overbilling now made regularly in the legislature and the press and it becomes appropriate, says the report, for the OMA to update its statement on billing practices and to lay down some firm guidelines for its members — "To spell out in detail its attitude on this fundamental matter of ethical behaviour."

That the OMA urge the government to devise some practicable means of informing the patient of OHIP billings.

In order to bring Ontario patients into the billing process, to let them know what their money is going for and how much health care is actually costing, the Pickering commission recommends adding this other dimension to the billing mechanism.

It notes that in Manitoba each patient is given a statement providing details about the nature of service, and amount paid by government on the taxpayer's behalf. There is a similar notification program in Quebec.

This device acts as a two-edged sword, says the report. "It tells members of the general public who are overusing the system that this is all a matter of record, and reminds others of the actual cost of their medical treatment. It likewise provides a built-in check for the doctor who is tempted to overbill."

MMA completes slate

The 1973-74 slate of officers of the Manitoba Medical Association has been completed with a mail-in ballot of the membership.

Dr. Edward Abbott, Winnipeg, was elected vice-president, Dr. Joseph Crust, Winnipeg, honorary treasurer, and Dr. William Ewart, Winnipeg, honorary secretary. Other officers were elected earlier at the MMA annual meeting.

BCMA annual meeting in Vancouver shows signs of growing togetherness

The 1973 British Columbia Medical Association annual meeting in Vancouver last month was turbulent and decisive, but the anticipated apocalypse did not occur. The traumatic confrontation of the 1972 meeting in Penticton had cast an atmosphere of apprehension over not only this meeting but also the CMA annual meeting (also in Vancouver) in mid-June. CMA delegates from the rest of Canada now can travel west with less trepidation.

According to observers and participants at the meeting, the "reform" and "establishment" factions of the association have come closer. The reasons for this partial rapprochement vary according to the opinion of those that you consult. Several claim, privately, that the establishment supported by the majority of association members that do not belong to one or the other camp, soundly defeated the reform movement tactically and in the all-important elections.

Dr. J. W. Ibbott, new chairman of the General Assembly attributed it to "a return of the pendulum of the profession in B.C. to a more central position."

Dr. John O'Brien-Bell claims that the reform group, of which he is a leader, has accomplished what it set out to do before the meeting began. Fee increases are now negotiated with the provincial government by a three-member team, picked on ability. Dr. O'Brien-Bell also points out that the results of the negotiations are subject to a referendum by the association membership.

A third goal, he said, was to shake members out of their apathy. This has apparently succeeded. More than 400 of the 3500 physicians in B.C. pre-registered for the meeting and about 650 were present to vote the selection of officers.

To others, the thickening of the association's political middle is largely due to a change in government. Access to the Social Credit government of W. A. C. Bennett, ousted by the NDP last August, was unusually difficult in recent years. Fee negotiations were strained. Premier Bennett placed a moratorium on fee increases in 1970 and set a 6.5% average actual increase in fees in 1972, a few weeks before last year's annual meeting in Penticton.

As a result, said Dr. Ibbott, who defeated "reformer" Dr. Victor Dirnfeld for the chairmanship of the general assembly, physicians from sections who had their fees cut by an association committee to meet the 6.5% increase descended on Penticton and joined forces with the "reform" group in vilifying the "establishment".

"As a result of the shock effect of the revision last year, many individual sections of the association were led to an awareness of the principle of a relative value fee schedule," said Dr. Ibbott, "and this prompted the sections to come to the economics committee of the association with sound ideas, which were their own, as to how best their schedule could be rearranged."

Tempering factor

Apart from more activity by some members in their association, another tempering factor on the two factions has been the style of the new NDP government and the personality of Health Minister Dennis Cocke. Association executives agree that access to Mr. Cocke has been direct and that this year's fee negotiations were achieved with a minimum of fuss.

The apparent or temporary detente was reflected in the remarks of some of the new officers associated with opposing groups. New president Dr. Kenneth C. Hill, elected president-elect from the "reform" group at Penticton last year, said that activism within the association "had its place, more so in the past.

"There was more apathy in the profession one or two years ago and the so-called activism has hopefully stirred the membership out of its apathy and got them involved in the affairs of the association.

"As a result we can direct our affairs more democratically", he said. "Having a difference of opinion brings out a consensus which has a better end product.

"The activists have been most active in the medico-political arena. I would personally like to see a greater degree of involvement in other areas and perhaps we can now stimulate our members to become more involved in planning council reports and other matters."

Dr. Hector Gillespie, who unsuccessfully ran against Dr. Hill last year but who was elected this year as president-elect, beating reformer Dr. Fred Ceresney, said there was certainly a compromise possible between the two factions. "I hope this kind of division will end in B.C. and that we get together and get the best ideas from each area and present a united front," (to the government) he said.

Public relations debate

Dr. Gillespie, like Dr. Hill an orthopedic surgeon, was elected president-elect following a long debate over the public relations committee report. The content of the *B.C. Medical Assn. News,* a newspaper devoted to medico-political matters edited by Dr. O'Brien-Bell, was criticized. The News has been used by the reform group to attack the establishment and last year the association executive vetoed an article on balance billing — on the grounds that it would prejudice

membership voting in the referendum on newly-negotiated fees. During the public relations committee debate this year the general assembly decided that a member of the committee would vet the front page of the News with Dr. O'Brien-Bell before publication.

Another general assembly decision was to transfer the voting for elected officers from the general assembly to the entire membership through mail ballot. In the BCMA, all members have the right to speak and vote at the general assembly. Now voting privileges on the election of officers have been extended to members not attending the general assembly, in effect making a mail vote possible.

The mail-ballot motion was opposed by the reform group. Reformers said its effect would be to dilute the power of members interested enough in association affairs to attend the general assembly in favour of the apathetic who stayed at home. They also saw the motion as an attempt by the establishment to ensure that nominees with minority views would have less chance of being elected by a general assembly controlled by activists. Reformers said the motion was prompted by the inroads which the reform candidates made into the association's positions of power at last year's annual meeting at Penticton.

Main aggravation between the reform and establishment groups noticeable to an observer was in the presidential address by Dr. David Bachop. Dr. Bachop berated the reform group. His criticism of the group has been interpreted by some BCMA members as the parting shots of a man whose life has been made miserable by the group. Others saw it as a skillful move to wean support from the reform group.

Dr. Bachop called for unity and issued a strong warning against the reform group "representing a minority of physicians in the province but strident and vocal beyond their stature."

The group's tactics have had a certain effectiveness, Dr. Bachop said, since any well organized, militant minority will always have an edge over an unorganized, silent majority.

The group refuses to accept decisions democratically arrived at by the majority and appears to court confrontation with the government, especially in financial matters, "a disaster from which recovery would be painful and protracted in the extreme," he said.

"Although some excellent ideas have come from this group as a minority, I fear that their leaders' immaturity, lack of judgement and political ineptitude when dealing with government make them totally unsuitable to become the majority group within our organization, if indeed a profession we wish to remain."

Lauds minister

Dr. Bachop reiterated that the profession must preserve its independence, applauded the open-mindedness of Health Minister Cocke, and warned that physicians must pay more attention to the consumer.

Allowing that some differences with the government are inevitable — "you cannot take 3500 doctors caring for two million plus people and the bills being paid by government dollars without some friction" — Dr. Bachop said the association's relation with the new NDP government, in particular, has been more than satisfactory.

"We have had a series of meetings to discuss problems of mutual concern and the atmosphere in which such meetings are held can do nothing but further the aims of both government and physicians in their joint provision of medicare," he said.

Dr. Bachop rejected the proposal to the Quebec Legislative Assembly that would allow government to place its own servants in key positions within professional groups. Even if the government appointees were members of the profession, they would be paid by, and be responsible to, the government, he said.

Dr. Bachop said that if it is true that each member of the public holds his personal physician in esteem but dislikes the profession as a whole, "we must ask ourselves why, and having found the answer, we had better move quickly to correct the problem.

"Somehow our public image is being damaged; we are becoming a political football perhaps, or a convenient whipping boy. But at any rate the message is clear. No longer can we say 'do it our way and don't ask why'."

He said he believed the association feels a special sense of professional obligation to society, and that patients recognize it in each individual physician as an individual. But the body corporate of physicians had a lot of catching up to do.

"We must be more aware of changing trends. While it was desirable or even necessary to be aloof and Olympian when our treatment was empirical at best, this attitude is no longer acceptable in this modern day and age when the science of medicine threatens to leave the art far behind," he said. "We must guard against treating our patients as diseases to be conquered rather than as human beings."

Challenge

Dr. Bachop's mention of physicians' relations with the public, his defence of the independence of physicians, and his opinion of Minister Cocke, touch upon perhaps the most important challenge facing the association in the immediate future, a challenge that may have been another reason for the apparent reconciliation of the two factions, the challenge of new methods of delivering health care.

Soon after his appointment as Health Minister, Mr. Cocke named Dr. Richard Foulkes as a special assistant. Dr. Foulkes, former executive director of the Royal Columbian Hospital in New Westminster, was appointed head of the government's health security program project, a task force to examine delivery of health care in the province, and was asked to submit a report by Oct. 1 of this year.

Both Mr. Cocke and Dr. Foulkes have publicly stated they favour community health centres. The relationship between the two men and the BCMA, however, differs widely.

Three weeks before the BCMA meeting Dr. Foulkes was reported in the press as saying he would urge the provincial government to set up community health centres staffed by physicians on salary. He was also reported as saying that B.C. physicians choose patients needing expensive surgical procedures over those requiring routine examinations

which pay less money, and that government might start examining medical records to make sure physicians are devoting enough time to make an adequate diagnosis of their cases.

Dr. Foulkes later said he was misinterpreted but not before then BCMA president Dr. Bachop dismissed Dr. Foulkes' charges as a "lot of hooey". In a formal statement issued later, Dr. Bachop said that Dr. Foulkes statements "effectively belied any objectivity that we hoped he would bring to his task.

"It was preposterous for him to state that doctors select patients who require expensive treatment in order to increase their income. This is an outrageous statement and to my knowledge cannot be supported by documentation."

Both Dr. Hill and Dr. Ibbott question Dr. Foulkes' suitability to head the task force because of the little experience he has had in practice.

Some observers said Dr. Foulkes has done much to show both the reform and establishment groups their common interests. As Dr. Gillespie pointed out, both factions are opposed to the elimination of the fee-for-service method of paying for medical services.

Dr. Hill says the government threat to the membership has changed. Under Social Credit the threat was economic and revolved around negotiations for new fee schedules. "It was a threat in terms of the unknown and the methods used," Dr. Hill said. "The threat today is, 'what's going to happen to me because of changes in the philosophy of the government concerning the health care system?'

Dr. Hill added that the public doesn't know enough about the issue to have any opinion as to whether physicians should be on salary or how they should be paid for their services. The NDP government's desire for salaried physicians is doctrinaire, he said.

Impressed

Despite what might be the government's intention of staffing community health centres with salaried physicians, many BCMA officers make a large distinction between the minister and his special assistant.

"From my dealings with the minister I've been very impressed," said Dr. Hill. "We have been able to discuss on a rational basis the issues before us and I hope this can continue."

Mr. Cocke was invited to speak on the last day of the meeting, the first provincial health minister to speak to the BCMA in an amicable atmosphere in more than two decades, said Dr. Ibbott.

Mr. Cocke, like Dr. Bachop, asked for the association to cooperate with government. He tried to remove fears physicians might have about the government's intentions but also challenged the traditional physician defence of the fee-for-service and doctor-patient relationship.

Referring to the Dr. Foulkes incident, he said that he regretted it had been introduced to strain the relationship between himself and physicians. The view of the provincial government, he said, was that doctors in B.C. are hardworking, honest, dedicated men and women whose overriding concern is for the welfare of their patients.

"Like the rest of us," he said, "they have to earn a living, and they have to do so within the confines of a system that is not of their own making."

Disenchantment

But one of the problems he is facing, the minister said, is the growing disenchantment of the public about the standards of health care they are receiving. This is apart, he said, from the problem of skyrocketing health costs.

Mr. Cocke said his impression is that there are three reactions among physicians to the idea of community health centres. Some favour the centres and want to work in them. Others don't want to work in the centres but feel that other doctors should be allowed to do so. The third group rejects the centres for themselves and for other physicians.

He said he didn't see the possibility now or in the future of any physician being asked to work in a delivery system not of his choice. There is also some opinion and supporting evidence that community health centres may, at least initially, add to the cost of health care, he said.

He said physicians are concerned "that valuable patient-doctor relationships could be jeopardized in this clinic concept. Many consumers are convinced that this relationship," Mr. Cocke said, "is somewhat of a myth and say they feel no personal relationship with their doctors."

He said it is difficult for the medical profession to convince the public that when they talk about fee-for-service versus salary that their concerns are anything but pecuniary.

"Virtually all other people involved in the delivery of health care are on a salary basis. There is no evidence that the public experiences a poor standard of service or that persons involved in nursing, x-ray and laboratory work are unfulfilled."

"There are those who believe in one system of remuneration and others who believe in the other. For now at least let's live and let live — without jeopardizing the standard of health care to the consumer."

PETER THOMPSON

Les structures administratives de la loi 65: lenteur et rigidité

Une fois de plus, les médecins ont essayé de comprendre comment pratiquer à l'intérieur des nouvelles structures proposées par les règlements de la loi 65 sur les services de santé et les services sociaux.

Au cours du 35ème congrès annuel de l'Association Médicale du Québec, qui a eu lieu à Chicoutimi, une centaine de membres de l'AMQ ont étudié trois des principales implications de cette loi.

Structures administratives

Les médecins croient que les nouvelles structures administratives ne pourront être adaptées facilement aux besoins changeants de la population à cause de la lourdeur des structures opérationnelles. L'énorme bureaucratie créée au niveau régional ne fera qu'augmenter les coûts des services de santé. Le nombre accru des intermédiaires sera partiellement responsable de cet état de faits.

Une des principales lacunes des règlements est la rigidité des structures. Le docteur Gustave Gingras, président de l'Association Médicale Canadienne et membre de l'AMQ, a demandé s'il serait possible qu'une seule et même personne cumule les charges de directeur des services professionnels, qui a droit d'autorité sur les médecins et les dentistes d'un hôpital, et de directeur des services hospitaliers, qui s'occupe des paramédicaux pratiquant à l'intérieur des hôpitaux. Le ministère des Affaires sociales s'oppose à cette duplication des tâches, qui serait pourtant souhaitable non seulement au point de vue économique mais aussi pratique. Le docteur Gingras croit que cette décision entraînerait une meilleure coordination du travail de tout le personnel hospitalier, y compris les médecins.

A cette fin, le docteur Fabien Poulin, qui a été élu président de l'AMQ au cours du congrès, a proposé que le gouvernement revienne à sa position initiale qui voulait que le directeur des services professionnels soit en charge de tous les paramédicaux. Cette résolution a été votée à l'unanimité par l'assemblée.

Les quelques 150 participants ont également eu la chance de se familiariser avec la notion et le rôle d'un Conseil Régional de la Santé et des Services Sociaux. Le docteur Raymond Carignan, un des panelistes invités et président du CRSSS Laurentides-Lanaudière a expliqué les objectifs de cet organisme qui est composé d'un conseil d'administration de 21 membres nommés pour deux ans. En plus d'améliorer les conditions sociales et la santé de la population, le CRSSS essaie de rendre les services et les soins plus accessibles, d'encourager la participation de la population, d'adapter les services et les soins aux besoins de la communauté. Il sert également de lien entre la région, le ministère des Affaires sociales, les établissements et les différentes ressources de la santé et des services sociaux.

Le docteur Carignan a expliqué qu'en plus de faire des recommandations, le CRSSS possède des pouvoirs d'exécution pour tous les mandats que veut lui confier le ministère des Affaires sociales. Actuellement, le CRSSS Laurentides-Lanaudière est à étudier les services d'urgence de la région afin de voir de quelle façon ces services pourraient être coordonnés au niveau régional.

Accessibilité

Les nouvelles structures administratives auront un effet déterminant pour ce qui est de l'accessibilité aux soins. C'est dans cet optique que le docteur Paul Landry a fait part de son expérience à titre de médecin pratiquant au Centre Local de Services Communautaires Hochelaga-Maisonneuve. Il a expliqué que le module principal du CLSC est l'accueil. Un travailleur social reçoit les patients et les dirige vers un médecin, un psychologue, ou un autre membre de l'équipe qui répondra à ses problèmes.

Selon le docteur Landry, le CLSC est la porte d'entrée dans le système et permet aux citoyens de prendre en charge et d'organiser les services disponibles, d'en créer d'autres pour répondre aux besoins de la communauté et d'animer le milieu afin de trouver une solution aux problèmes. Le programme est axé sur la prévention et le travail d'équipe.

Cet idéal décrit par le docteur Landry doit se réaliser dans le cadre d'un contexte réel, ce qui soulève un grand nombre de difficultés. La structure de participation est lourde, lente et inefficace. Les conflits d'idéologie entraînent des débats et plusieurs des participants ont été désillusionnés parce que la réalité n'avait pu répondre à leurs aspirations.

Un autre problème discuté au cours du congrès a été la pénurie de médecins à l'extérieur des grands centres. A cause des désavantages, les médecins ne veulent pas pratiquer dans les régions éloignées. Au cours d'un atelier de travail sur ce sujet, les participants ont proposé des solutions qui allaient des subventions aux patients qui doivent se déplacer aux bonis que le gouvernement pourrait verser aux médecins qui vont dans ces régions, en passant par la conscription obligatoire, l'augmentation des structures et des facilités locales afin d'attirer les médecins et un programme qui viserait à sensibiliser la population à ce problème.

Formation des para-médicaux

Le troisième sujet discuté par les participants touchait l'équipe multi-

De gauche à droite, on aperçoit le docteur Fabien Poulin, nouveau président de l'AMQ, qui s'entretient avec les docteurs Gustave Gingras, président de l'AMC et Guy Joron, ancien président de l'association provinciale.

disciplinaire, son mode de fonctionnement et la formation de ses membres. L'atelier de travail a suggéré qu'un coordinateur de tous les services et traitements devrait suivre le patient à travers les étapes de son passage à l'hôpital. Ce rôle pourrait être accompli par un omnipraticien qui serait formé en fonction de ses nouvelles attributions.

Cette approche multi-disciplinaire prévaut surtout dans les cas graves lorsque les services de plusieurs spécialistes médicaux et para-médicaux doivent être coordonnés.

Quant au nombre de médecins disponibles au Québec, le docteur Augustin Roy, registraire du Collège des Médecins et Chirurgiens, a souligné que la province avait presque atteint le point de saturation prévu dans le rapport de la commission Hall. Un autre participant a fait remarqué qu'il fallait maintenant former des para-médicaux afin de permettre aux médecins de déléguer des pouvoirs et de suffire à la demande.

A ce sujet, le docteur Gingras a ajouté que, s'il existait une pénurie, elle n'était sûrement pas attribuable aux restrictions imposées à l'immigration des médecins formés à l'étranger. Il a déclaré: "En 1972, des 656 nouveaux médecins licenciés au Québec, 343 avaient obtenu leur doctorat à l'extérieur de la province."

Au cours de l'assemblée générale, le président de l'AMC a également soulevé la question de la hausse des coûts des soins hospitaliers. Selon lui, cette augmentation ne fait que "corriger une des grandes injustices de notre temps." En effet, les services des religieuses et des bénévoles sont maintenant rénumérés et les salaires dérisoires versés au personnel hospitalier ont enfin été augmentés, entraînant une hausse considérable. Le docteur Gingras a fait remarquer que "70% du budget d'un hôpital passe maintenant en salaires."

Pendant l'assemblée, les membres de l'AMQ ont élu leur nouveau président, le docteur Fabien Poulin de Montréal qui succédera au docteur Guy Joron et lors du banquet présidentiel, le docteur Roméo Cantero, gastroentérologue, a été nommé membre émérite de l'association nationale.

L. de G.